BEFORE THE ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

IN THE MATTER OF: **JEREMY SHAPERO, DVM** HOLDER OF LICENSE NO. 7407 FOR THE PRACTICE OF VETERINARY MEDICINE IN THE STATE OF ARIZONA, **RESPONDENT.**	**CASE NO.: 22-76** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER**

The Arizona State Veterinary Medical Examining Board ("Board") considered this matter at its public meeting on August 17, 2022. Jeremy Shapero, DVM ("Respondent") appeared on his own behalf and represented by attorney, W. Reed Campbell, for an Informal Interview that was held pursuant to the authority vested in the Board by A.R.S. § 32-2234(A). After due consideration of the evidence, the arguments and the applicable law, the Board voted to issue the following Findings of Fact, Conclusions of Law and Order ("Order").

FINDINGS OF FACT

1. Respondent is the holder of License No. 7407 and is therefore authorized to practice the profession of veterinary medicine in the State of Arizona.

2. On November 12, 2021, "Kelvin," a 10-year-old Golden/Lab mix was presented to Respondent for quality of life evaluation due to pain and decreased mobility in the hind end. Complainant reported that the dog was healthy other than his bowed back legs. The dog was becoming weaker in the hind end and would occasionally fall on his daily walks. Complainant wanted to explore options and if surgery was needed, would it be worth it. The dog was

currently taking gabapentin, meloxicam, glucosamine and fish oil. Upon exam, the dog had a weight = 74.6 pounds (overweight), a temperature = 100.3 degrees, a pulse rate = 120bpm and a respiration rate = 40+rpm. Respondent noted that the dog had decreased muscle mass in the hind legs, right rear leg was severely toed-in, and there was marked buttressing of the right rear leg. His assessment was hip dysplasia, suspected degenerative myelopathy, osteoarthritis, and overweight. Respondent recommended blood work and radiographs and an estimate was provided for the recommended services.

3. On November 15, 2021, the dog was presented to Respondent for radiographs and blood work. According to Respondent, he discussed the radiographic findings with Complainant. Radiographs of the pelvis revealed a bad hip, asymmetrically, and arthritis in the stifles. He explained that if the hip was the source of discomfort, being a unilateral problem, this could potentially be fixed with an FHO (femoral head ostectomy) – therefore surgery was discussed. Respondent stated that surgery would not return the dog to his baseline normal function, but given his muscle weakness and other arthritic ailments, it could improve his current condition. Complainant was satisfied with this idea.

4. On November 18, 2021, Respondent's associate Dr. Pike left a message with Complainant with the blood results. She stated that if the medication was no longer helping and if it was difficult to manage the dog, then euthanasia was not a bad option. Dr. Pike relayed that the dog likely had degenerative myelopathy which has no cure and minimal treatment.

5. According to Respondent, he called Complainant with the lab results, which were largely normal and Valley Fever negative. The dog would be a

capable candidate to undergo anesthesia. Complainant stated she would call back to schedule the procedure.

6. On November 23, 2021, Complainant called Respondent to relay that she was interested in scheduling the FHO.

7. On November 29, 2021, the dog was presented to the premises to be vaccinated. The FHO surgery was scheduled for December 2, 2021.

8. On December 2, 2021, the dog was presented to Respondent for a FHO surgery. Complainant reported that the dog had his dose of gabapentin and meloxicam that morning. Upon exam, the dog had a weight = 73.6 pounds, a temperature = 102.1 degrees, a pulse rate = 140bpm, and a respiration rate = 40rpm. An IV catheter was placed and the dog was started on IV fluids; pre-medicated with atropine 3.0mLs SQ; induced with ketamine 100mg/mL/valium 5mg/mL - 3.0mLs IV; and maintained on isoflurane and oxygen. The dog was administered Pen G 3.0mLs SQ.

9. Respondent stated in his narrative that staff asked which leg to prep for surgery; Respondent stated left. However, Complainant stated right leg therefore Respondent had staff repeat radiographs to confirm. He also re-evaluated the dog and noted drawer in the right stifle that was not felt when the dog was evaluated while awake at the original exam. Respondent called Complainant to advise her of the new findings and how the drawer in the right stifle was diagnostic for cruciate ligament tear which would be in conjunction with the degenerative joint disease in the stifles. He recommended a TPLO surgery of the right stifle and provided Complainant with the recovery and cost differences. Respondent stated that he also offered to postpone the procedure

to another day or proceed with the TPLO; Complainant elected to proceed. Complainant denies that she was offered postponement of the procedure.

10. The dog was discharged later that day with discharge instructions, TPLO after care, and the following medications:

a. Cefopodexime 200mg, 7 tablets; give one tablet once a day orally; and

b. Meloxicam 7.5mg, 60 tablets; give ½ - 1 tablet orally once a day as needed for pain (call in to Costco).

11. On December 6, 2021, Complainant left a message reporting the dog's leg was flopping. Technical staff member, Romy, was in contact with Respondent – he recommended kennel rest, continuing the medication and bring the dog in to be seen on 12/8. Romy was told by Complainant that she was not kenneling the dog; he has been running and jumping without supervision. Complainant agreed to bring the dog in on 12/8. Complainant denies this allegation.

12. Complainant called again reporting she took the bandage off and there was an opening in the incision. Romy explained that Respondent's associate did not feel comfortable evaluating the dog therefore continue confinement and bring the dog in on 12/8. Complainant stated that she placed steri-strips on the opening and rewrapped the dog's leg. She relayed that there was no redness or swelling of the affected joint and would send pictures for Respondent.

13. On December 7, 2021, the dog was presented to Respondent's premises for radiographs and to repair the incision dehiscence. Respondent was not in that day therefore Romy, under Respondent's associate's supervision (Dr. Pike)

placed staples to the incision. Radiographs were taken and sent to Respondent for review. The pet owner (Complainant's daughter) was instructed to bring the dog back the following day for Respondent to examine the dog.

14. On December 8, 2021, Complainant did not bring the dog in for Respondent to examine. She was called and did not understand why she the needed to return since he was there the day before. Complainant wanted to speak with Respondent and reported that the dog's bandage fell off already. Respondent attempted to return Complainant's call; he had to leave a message.

15. On December 17, 2021, Complainant left a voicemail stating she requested a refill of meloxicam a week ago. They had record that a refill request was called in on 12/3. Costco confirmed they did not receive the voicemail. Respondent's staff requested they fill the medication with one refill.

16. On December 20, 2021, Complainant texted the premises stating that after the placement of staples, they all fell out except for two and the original suture continued to unravel leaving a big string. Since she never heard back from Respondent or the premises, she did the best she could. Complainant further stated that the dog could not walk and knuckled on both feet. Additionally, she did not get the medical records or radiographs as requested. Complainant wanted to know if she would be able to speak with Respondent at the suture removal as she was concerned that the dog was not walking. If she had to go to an emergency facility, Complainant felt Respondent should pay for the visit.

17. Premises staff returned Complainant's text message advising that Respondent could see the dog on 12/22. She was told that Respondent had spoken to someone about the dog's care and also left a voicemail.

18. On December 21, 2021, Complainant texted that there was a pin protruding from the dog's skin. They had complied with the aftercare instructions except for the physical therapy. The dog was painful. Complainant expressed her frustration that Respondent had not returned her call and was concerned that he was not getting her messages. Staff ensured her that Respondent was receiving her multiple messages.

19. That afternoon Complainant again texted the premises stating she was having an emergency with the dog and requested a call. Since no one called Complainant again texted saying she was taking the dog to an emergency facility and she expected Respondent to pay for the visit due to neglect and no return call. Respondent's staff messaged back that if Complainant took the dog to an emergency facility, it would be at her own cost. However, Respondent ordered antibiotics for the dog which could be picked up that day and Respondent would see the dog the following day. Complainant texted several more times to express her dissatisfaction with their services.

20. On December 22, 2021, the dog was presented to Respondent. Respondent met with Complainant at length following hostile emails (texts). Despite Complainant's claims of incision dehiscence, the incision was completely and well healed, although a screw was palpably quite loose and protruding. There was marked bruising of the site but no discharge. Respondent discussed with Complainant that they knew going into the procedure that the

dog had nerve problems, they could attempt to repair or they may have to consider the dog's quality of life. Complainant wanted to try surgery.

21. Respondent advised Complainant that x-ray machine was not currently working but was hopeful it would be fixed later that day to be able to fully evaluate the dog's leg. Later that day, Respondent called Complainant to let her know that it was likely that the x-ray machine would not be repaired that day. He offered to wait to do the procedure, have the radiographs performed at another premises, or proceed with without radiographs. Complainant elected to proceed with the surgery.

22. Respondent examined the dog; an IV catheter was placed – unknown if fluids were started; atropine was administered and the dog was induced with ketamine and valium. Respondent repaired the pin rejection.

23. The dog was discharged with cefpodaxime 200mg, instructions to remove the bandage in 5 – 7 days, and suture removal in 14 days – recheck radiographs at that time.

24. On December 28, 2021, Complainant texted the premises stating that the pin was coming out again. She texted multiple times within an hour. Premises staff advised that their x-ray machine was still not working but the other location could help her. Complainant took the dog to an emergency facility instead.

25. The dog was presented to Veterinary Specialty Center of Tucson with concerns of an infection of a surgical implant. The dog had a diminished appetite. Dr. Snyder noted the surgical incision was draining on medial aspect and appeared to be healing adequately. There was moderate erythema around incision and caudal to incision. Additionally, there were two small

puncture wounds present caudal to incision with firm protuberance deep to the distal wound. Radiographs were performed and a non-union fracture of the surgical site was suspected, as well as a damaged orthopedic plate and rejection of orthopedic screw. The findings were discussed with Complainant along with possible treatment options. Complainant had financial constraints and the dog had a history of other mobility issues therefore humane euthanasia was elected.

26. The following day, Respondent called Complainant after receiving information that Complainant was again sending hostile messages the previous day. Complainant reported the dog had been euthanized due to implant failure.

27. The Board did not believe that the orthopedic plates were damaged; the plates are made to conform to the animal's bone.

28. The Board determined that Respondent did not meet professional acceptable procedures by not discussing the dog's multiple concerning conditions with Complainant which could impact the dog's recovery and prognosis after orthopedic surgery.

CONCLUSIONS OF LAW

29. The conduct and circumstances described in the Findings of Fact above, constitutes a violation of **A.R.S. § 32-2232 (12)** as it relates to **A.A.C. R3-11-501 (1)** failure to provide professionally acceptable procedures by not fully educating the pet owner on the dog's multiple conditions, what surgical techniques were going to entail and their prognosis.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law it is **ORDERED** that Respondent's License, No. 7407 be placed on **PROBATION** for a period of one (1) year, subject to the following terms and conditions that shall be completed within the Probationary period. These requirements include six (6) total hours of continuing education (CE) detailed below:

1. **IT IS ORDERED THAT** Respondent shall provide written proof satisfactory to the Board that he has completed six (6) hours of continuing education (CE); hours earned in compliance with this order shall not be used for licensure renewal. Respondent shall satisfy these six (6) hours by attending CE in the area of client communication. Respondent shall submit written verification of attendance to the Board for approval.

2. **All continuing education to be completed for this Order shall be pre-approved by the Board**. Respondent shall submit to the Board a written outline regarding how he plans to satisfy the requirements in paragraph 1 for its approval within sixty (60) days of the effective date of this Order. The outline shall include **CE course details** including, **name, provider, date(s), hours of CE** to be earned, and a **brief course summary**.

3. Respondent shall obey all federal, state and local laws/rules governing the practice of veterinary medicine in this state.

4. Respondent shall bear all costs of complying with this Order.

5. This Order is conclusive evidence of the matters described and may be considered by the Board in determining an appropriate sanction in the event a subsequent violation occurs. In the event Respondent violates any term of this Order, the Board may, after opportunity for Informal Interview or Formal

Hearing, take any other appropriate disciplinary action authorized by law, including suspension or revocation of Respondent's license.

NOTICE OF APPEAL RIGHTS

Respondent is hereby notified that he has the right to request a rehearing or review of the Order by filing a motion with the Board's Executive Director within 30 days after service of this Order. Service of the Order is effective five days after the date of mailing to Respondent. *See* A.R.S. § 41-1092.09. The motion must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R3-11-904. If a motion for rehearing or review is not filed, the Board's Order becomes final 35 days after it is mailed to Respondent. Respondent is further notified that failure to file a motion for rehearing or review has the effect of prohibiting judicial review of the Order, according to A.R.S. § 41-1092.09(B) and A.R.S. § 12-904, et seq.

Dated this 7th day of October, 2022.

Arizona State Veterinary Medical Examining Board
Jessica Creager
Chairperson

By: Victoria Whitmore
Victoria Whitmore, Executive Director

Original of the foregoing filed this 7th day of October, 2022 with the:

Arizona State Veterinary
Medical Examining Board
1740 W. Adams St., Ste. 4600
Phoenix, Arizona 85007

Copy of the foregoing sent by certified, return receipt mail this 7th day of October, 2022 to:

Jeremy Shapero, DVM
Address on file
Respondent

By: _____
Board Staff